UTILIZATION REVIEW PLAN
University of California San Diego
Child and Adolescent Psychiatry Service (UCSD CAPS)

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DEFINITIONS

Acute Days: Medically necessary hospital inpatient days eligible for reimbursement by Short Doyle/MediCal (SD/MC), Realignment, or other funding sources.

Administrative Days: The days the patient's stay at the acute inpatient facility (UCSD CAPS) must be continued beyond the patient's need for acute care while waiting for placement at a lesser level of care treatment facility.

Admission Review: A review and decision process performed by the Reviewer to determine the medical necessity and appropriateness of admission to an inpatient level of care.

Adverse Decision: A determination by the physician advisor that a patient's condition does not justify reimbursement at the acute inpatient level of care.

Assessment: A formal, documented evaluation or analysis of the cause or the nature of the eligible patient's mental, emotional, or behavioral disorder. The assessment service is limited to an intake examination, mental status evaluation, physical examination, and laboratory testing necessary for the evaluation and treatment of the eligible patient's mental health needs.

Attending Physician: The physician primarily responsible for the care of the patient, including the development of the treatment plan, documentation of medical necessity, and discharge planning.

Exacerbation: A significant worsening of symptoms after a relatively stabilized and/or improved state requiring a change from non-acute to an acute level of care.

Feedback Loop: See McFloop

Level of Care (LOC): The type and intensity of patient services necessary for effective treatment of persons with mental disorders.

Licensed Clinical Social Worker (LCSW): A person possessing a valid license to practice as a clinical social worker granted by the California State Board of Behavioral Science Examiners.

Licensed Vocational Nurse (LVN): A person possessing a valid license to practice vocational nursing granted by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

Marriage and Family Therapist (MFT): A person possessing a valid license to practice as a marriage and family therapist granted by the California State Board of Behavioral Science Examiners.

McFloop: The Multiuse Complete Feedback Loop is issued by the Utilization Review Specialist or the Utilization Review Committee as a form of peer review to physicians and primary clinicians where there is a failure to adhere to regulations or lack of appropriate documentation

in the clinical record. A feedback loop is a form that details what the particular problem is and asks for a resolution or explanation. The Utilization Review Committee or committee designee issues the feedback loop to the clinician only when the child is in-house. The clinician returns the feedback loop with requested information within two weeks and under no circumstances are changes to a closed record requested. A feedback loop may be used for a record after discharge only for Utilization Review Committee inter-rater reliability purposes.

Medical Care Evaluation (MCE) Study: A study that is intended to investigate serious existing or potential service delivery problems. This is accomplished by using a research design consisting of predetermined document screening criteria, valid sampling techniques, analysis of findings, and recommendations for corrective action, if necessary.

Medicaid: The federal and state program that provides federal reimbursement to states for the costs of medical care for the poor and disabled.

Medi-Cal: California's Medicaid Program is called Medi-Cal.

Medical Necessity: Acute inpatient mental health services are covered benefits of realignment and Medi-Cal Programs when:

1. An individual, as a result of a suspected or established diagnosis of mental disorder, poses substantial jeopardy to self or society.
2. An individual, as a result of a suspected or established diagnosis of mental disorder, exhibits confusion, impaired judgment, or uncooperative behavior to the extent diagnostic procedures and treatment could not reasonably be assured at a lower level of care.
3. Criteria are specifically detailed in the California Code of Regulations, Title 9, Chapter 11, Section 1820.205.

Non-Medically Necessary Hospital Stay (Non-Acute / Administrative): A hospital stay that continues beyond the acute phase for health and safety of the patient due to uncontrollable circumstances.

Payment Authorization Request (PAR): A written form specified by the Mental Health Plan to approve or deny inpatient Short-Doyle/Medi-Cal payment.

Payment Authorization Specialist: The person responsible for providing retrospective payment authorization on all discharged records to determine the approved acute days and administrative days.

Physician Advisor (PA) / Physician Reviewer: A Physician Advisor/Physician Reviewer is the San Diego County Contracted Physician who reviews cases retrospectively when there is a question of medical necessity and appropriateness of care.

Point of Authorization: The function within the MHP that is required to receive provider communications twenty-four hours a day, seven days a week, regarding requests for Mental Health Plan payment authorization of psychiatric inpatient hospital and authorizes payment for

those services. This function may be assigned to a person, an identified staffing unit, a committee, or an organizational executive who may delegate the authorization functions.

Principal Diagnosis: The diagnosis that is the focus of the current episode of treatment and is determined to be the reason for admission. The diagnosis must be consistent with the criteria specifically detailed in the California Code of Regulations, Title 9, Chapter 11, Section 1820.205.

Psychiatric Technician (PT): A person possessing a valid license to practice psychiatric nursing granted by the California Board of Vocational Nursing and Psychiatric Technician Examiners.

Psychiatrist: A person possessing a valid license as a Physician and Surgeon from the Medical Board of California along with evidence of completion of the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the American Medical Association or the American Osteopathic Association.

Psychologist: A person possessing a license to practice as a psychologist granted by the State Board of Psychology, Medical Board of California.

Quality Improvement Program Supervisor: A person who is responsible to supervise and coordinate all aspects of the Quality Improvement Program.

Quorum: A quorum is a simple majority of members of the Utilization Review Committee that includes at least two (2) physicians.

Realignment Funds: Funding by the State of California to provide mental health services for patients (or their representative) that have need but lack ability to pay for their services.

Registered Nurse (RN): A person possessing a valid license to practice as a registered nurse granted by the California Board of Registered Nursing.

Review: An evaluation and decision process by the Utilization Review Specialist/Coordinator for medical necessity, appropriateness of level of care, and intensity of professional mental health services provided.

Reviewer: A person authorized to review medical records for the purpose of performing Utilization Review. Authorized persons are the Quality Improvement Program Supervisor and Utilization Review Specialists.

Short Doyle/Medi-Cal: Mental health insurance funded by the State of California and the Federal government for patients determined eligible by Social Services.

Utilization Record: A record compiled by the Reviewer which includes Payment Authorization Requests, UR Worksheets and completed McFloop forms.

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UTILIZATION REVIEW REQUIREMENTS

Authority:

The San Diego County Health and Human Services Agency Mental Health Services Utilization Review Plan for the University of California San Diego Child and Adolescent Psychiatry Service (UCSD CAPS) is established in compliance with the authority of Federal laws and regulations, Joint Commission on Accreditation of Hospital Standards, State of California Department of Mental Health Short-Doyle/MediCal (SD/MC) Utilization Review Requirements and Procedures, and in accordance with California Welfare and Institutions Code as well as the California Code of Regulations.

The UCSD CAPS program is licensed by the State of California and is designated a Lanternman-Petris-Short (LPS) facility. UCSD CAPS is a County contracted program that provides comprehensive acute psychiatric inpatient services for child and adolescent residents of San Diego County who are in need of psychiatric care in a secure environment and who are referred to the UCSD CAPS facility by the County's Child and Adolescent Emergency Screening Unit (ESU).

Purpose:

Quality Management, Utilization Review, and Payment Authorization are administrative responsibilities mandated by Federal and State law for the purpose of systematically monitoring and authorizing the appropriateness and quality of admissions, continued stay and health services rendered to children and adolescents of a culturally diverse population within San Diego County.

Objectives:

To perform utilization review for all children and adolescents housed at USCD CAPS and receiving Medi-Cal services, on a timely basis, in accordance with federal and state laws and regulations.

To ascertain medical necessity, level of care, quality of care, and appropriateness of health care services in accordance with Federal and State laws and regulations.

To ensure that available resources, facilities, and services are being used efficiently and effectively.

To identify factors that may contribute to unnecessary treatment or inefficient utilization of facilities or services.

Scope:

This utilization review plan applies to all children and adolescents receiving mental health care and services in the UCSD CAPS inpatient hospital. Children and adolescent patients shall include, but are not limited to, the following groups: Lanterman-Petris-Short youth, including

involuntary and voluntary per various state codes (Welfare and Institutions Code 5585 et seq. and 6552 et seq., etc.); AB2726; acute and State Hospital populations; children and adolescents who are the responsibility of the County (Child Welfare Services or Probation Department); uninsured indigent clients; Medi-Cal eligible clients; and developmentally disabled clients needing acute psychiatric treatment. Utilization Review is limited to Short/Doyle Medi-Cal patients and those who become eligible for San Diego Medi-Cal retroactively. This plan includes:

- Acute Inpatient Care Services
- Non-Medically Necessary Hospital Stays

Organization:

The Quality Improvement Program is under the jurisdiction of the County of San Diego Children's Local Mental Health Director, who provides administrative support. County supervising psychiatrists provide medical direction.

UCSD CAPS administrator is responsible to ensure that the contract program is in compliance, at all times with the Quality Management / Utilization Review requirements in this plan.

The UCSD CAPS program is required to report suspected child abuse, AWOL incidents, morbidity and mortality incidents, suicides and suicide attempts to appropriate authorities and the program monitor. The UCSD CAPS program is responsible for performing ongoing quality review monitoring and quality assurance activities in compliance with JCAHO standards.

The Utilization Review Committee is a UCSD CAPS program committee designated for the purpose of reviewing clinical records for accuracy, quality of care, and inter-rater reliability on all Medi-Cal admissions, continued stays, and adverse decisions.

The Chief, Critical Care Services of the County of San Diego County will programmatically monitor UCSD CAPS program services.

The County Contract Operations unit performs administrative fiscal monitoring.
The County Quality Improvement Program Supervisor is responsible to supervise and coordinate all aspects of UCSD CAPS Utilization Review.

The County designated Payment Authorization Specialist is responsible to monitor and perform payment authorization for all UCSD CAPS children and adolescents receiving Short/Doyle Medi-Cal services.

The County monitors have access to clinical records and files, subject to state and federal laws governing confidentiality. County monitoring and Quality Improvement staff evaluate contract performance and compliance with the contract requirements including, but not limited to, the Utilization Review Plan, the Federal Code of Regulations, the California Code of Regulations, and related policies and procedures.

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Utilization Management:

The County shall pay compensation for services performed to UCSD CAPS monthly upon the County's receipt and approval of the properly completed claim and cost report forms for the period. UCSD CAPS conforms to Federal, State, and County regulations and allows access of records by the County Utilization Review Staff. UCSD CAPS is to maintain complete and adequate records that comply with the requirements of Title 9 of the State of California Code of Regulations.

Access to UCSD CAPS:

Crisis Consultation and Notification Services for children and adolescents are operated through the County's Emergency Screening Unit (ESU) services seven (7) days a week, 24 hours per day. Providers for children and adolescents are required to notify Crisis Consultation on all admissions prior to hospitalization by calling 619-421-6900.

Clinicians are available at all times to accept telephone or fax notification from Medi-Cal Managed Care providers. The notification also establishes communication with Child and Adolescent Transition Team Services. This communication link enhances continuity of care by alerting appropriate team members to the admission and potential discharge needs of the hospitalized individual. Patients eligible to receive SD/MC reimbursement funding will be reviewed in accordance with Criteria are specifically detailed in the California Code of Regulations, Title 9, Chapter 11, Section 1820.205.

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UCSD CAPS UTILIZATION PLAN

UTILIZATION REVIEW COMMITTEE:
Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.150-245
California Code of Regulations, Title 9, Chapter 11, Section 1820.210

The Utilization Review Committee (URC) at UCSD CAPS is multi-disciplinary team, representing a cross-section of personnel delivering services to children and adolescents, and is responsible to ensure that utilization review is performed in accordance with all state and federal regulations and requirements. The URC accomplishes this task by reviewing all Medi-Cal admissions. Records are reviewed for quality issues and adherence to regulations.

The URC is composed of two physicians who are board certified in child psychiatry, both of whom are knowledgeable in diagnosis and treatment of mental disease; two social workers, one psychologist; and two registered nurses. The URC may meet monthly, but at least quarterly. The URC elects a chairperson from among its members. A quorum, defined as a simple majority of the total number of members that includes at least two physicians, is required to make URC decisions. The chairperson conducts the URC meetings, approves and signs all minutes and correspondence.

A designee of the URC performs continued stay reviews for all Medi-Cal clients and tracks retrospective payment authorization done by the Mental Health Plan's Point of Authorization. The County of San Diego Mental Health Plan (MHP) has opted to provide payment authorization by a Point of Authorization, as permitted in the California Code of Regulations, Title 9, Chapter 11, Section 1820.215(a)(2)(A). The County of San Diego has contracted with Telecare, Inc., to perform payment authorization duties.

The Mental Health Plan's utilization review/quality improvement staff serves the URC as resource persons. County staff provides updates on state and federal regulations, feedback on adherence to regulations in the medical records, review of any or all medical records that may demonstrate problems, and do trainings as necessary. The URC is designed to be a collaborative effort to review any or all records with the purpose of enhancing the quality and appropriate utilization of services.

Reviewer Restrictions:
Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.206

No person having a financial interest in any mental hospital may serve as a member of the Utilization Review Committee.

The Utilization Review Committee may not include any individual who is directly responsible for the care of the patients whose care is being reviewed.

Minutes:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.212(a)

Minutes and records shall be maintained for three years. The original of the URC minutes and all attachments shall be kept on file in the UCSD CAPS administrative offices. A copy of the minutes shall be kept in the Quality Improvement Program administrative office. The minutes must include:

a. Name of Committee.
b. Location, date and duration of meeting.
c. Names of members present and absent by discipline.
d. Description of activities.
e. The number of cases reviewed, including recommendations and follow-up as appropriate.
f. Patient name, patient number and medical record number.
g. Period of time reviewed.
h. Copies of County Contracted Physician Advisor adverse decisions as evidenced by the Payment Authorization Request (PAR). If none, it will be so noted.
i. MCE studies completed or in progress of completion.
j. Signature and date of the Chairperson indicating review and approval of the minutes.

Records and Reports Kept by the URC:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.212(a)

a. **Medical Care Evaluation Studies** reports intended to investigate serious existing or potential service delivery problems. This is accomplished by using a research design consisting of predetermined document screening criteria, valid sampling techniques, analysis of findings, and recommendations for corrective action, if necessary.
b. **MultiUse Complete Feedback Loops** issued as a form of peer review to physicians and primary clinicians where there is a failure to adhere to regulations or lack of appropriate documentation in the clinical record. The form details the particular problem or issue and may or may not request a resolution or explanation. The feedback loop may also be used for a record after discharge only for URC inter-rater reliability purposes.
c. **Payment Authorization Requests** copies, completed and returned from the payment authorization specialist.
d. **Summaries of days denied** for either acute medically necessary or administrative non-medically necessary
e. **URC Meeting Minutes**

Distribution to Individuals of Records and Reports:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.212(b);
California Code of Regulations, Title IX, Chapter 11, Section 1820.220 (a).

a. Minutes are distributed to each member during the URC meeting. A copy is also distributed to the County's Quality Improvement Supervisor.

b. Medical Care Evaluation Study reports are distributed to all members at the URC meetings. The Medical Care Evaluation Committee may also distribute reports as determined by that committee.
c. Feedback loops and completed Payment Authorization Requests are not distributed, but summarized and documented in the minutes. Review of these records is on a 'need to know' basis.
d. Medically necessary (acute) and Non-medically necessary (administrative) Payment Authorization Requests will be submitted within fourteen (14) days post discharge by the Reviewer to the Payment Authorization Specialist. The payment Authorization Specialist will review, complete, and return the PAR within fourteen (14) calendar days.

Confidentiality of Records and Reports:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Section 456.213
Code of Federal Regulations, Title 45, Subtitle A, Subchapter C, Parts 160 & 164.

All records and reports that may identify a particular client use a client number identifier rather than a name and will comply with all Health Insurance Portability and Accountability Act of 1996 requirements.

Medical Care Evaluation (MCE):

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.241-243

Medical Care Evaluation Studies shall be conducted and reported by the UCSD CAPS URC for analysis and recommended changes for quality improvement. At least one study shall be completed annually and at least one study shall be in progress at all times. Samples drawn for study purposes will represent a mix of Short Doyle/Medi-Cal and realignment funds patients, as well as patients with other sources of funding. The method used to select shall be the high volume, or high risk and /or problem prone children and adolescents. Analysis may be directed towards admissions, durations of stay, ancillary services furnished including drugs and biologicals, and professional services performed in the hospital.

The results of the MCE studies and how the results have been used to make changes to improve the quality of and promote a more effective and efficient use of facilities and services will be documented and presented in the form of a report. The report will contain documentation of the analyzed data quarterly and at the end of each study. Documentation that actions have been taken to correct or investigate further any deficiencies or problems in the review process and recommendations of more effective and efficient hospital care procedures will be provided by the responsible UCSD CAPS staff.

Admissions:

An initial continued stay utilization review will be set for each admission within seventy-two hours after admission and by at least each seven days thereafter. In addition, each day's entries in the patient's medical record will be monitored for adherence to medical necessity criteria, or administrative day criteria if applicable. If any individual applies for Medi-Cal while in

the hospital, the initial continued stay review date will be assigned within one working day after the hospital is notified of the application for Medi-Cal.

Continued Stay:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.211; 231-236

a) The URC has developed interpretive guidelines to assess medical necessity, admission criteria, continued stay criteria, and discharge criteria as follows as outlined in Attachment 4.

The URC and the Point of Authorization utilize the California Code of Regulations, Title 9, Chapter 11, Section 1820.205(a-c) describing medical necessity criteria for admission and continued stay. (Attachments 1 & 2) The contract between the Mental Health Plan and the State Department of Mental Health requires the utilization of these specific criteria. The California Code of Regulations, Title 9, Chapter 11, Section 1820.215(j)(4) requires that the Point of Authorization approve payment for continued services when written documentation meets medical necessity criteria for each day of service. Days that are not found to be medically necessary and that do not qualify for administrative day consideration will be denied for Medi-Cal payment and be billed to the County of San Diego as unfunded (realignment) days.

b) The URC has developed more extensive criteria for cases that are associated with high costs and possibly excessive services as follows:

1) Potentially high number of administrative days due to lack of placement options
2) 1:1 staffing on a daily basis

All review dates by the URC will be entered into the medical record by a member of the URC.

A designee is appointed by the URC to review each continued stay on or before the expiration of each assigned continued stay review date. The designee reviews and evaluates the documentation against the established criteria in (a) and applies close professional scrutiny to cases described in (b), above.

Adverse Decisions:

If the designee finds that a continued stay does not meet the criteria, the URC or a subgroup that includes at least one physician reviews the case to decide the need for continued stay. If this group finds that a continued stay is not needed, it notifies the attending or staff physician via a feedback loop and permits that physician to present his or her reasons and plan before making a final decision. If the attending or staff physician does not present additional information or clarification of the need for continued stay, the decision of the URC or subgroup is final. If the attending or staff physician does present additional information and clarification, then the two physicians of the URC, one of whom is knowledgeable in the treatment of mental diseases, review the need for the continued stay. If the two (2) physicians of the URC find that there is no need for further inpatient mental hospital services, their decision is final.

Written notice of any adverse final decision shall be sent to the hospital administrator, the attending or staff physician, the Medicaid agency, the beneficiary and responsible

parent/guardian/social worker. The written notice must be given within two working days after the assigned continued review date or within two working days of the final decision if the decision was made before the review date.

Administrative Days:

California Code of Regulations, Title 9, Chapter 11, Sections 1810.202 & 1820.220(j)(5)(A)-(B).

Children/adolescents who must remain in the hospital for circumstances beyond their control, but who no longer need acute care, may be granted administrative days, if the circumstances preventing the discharge fall within the parameters of the criteria of the California Code of Regulations, Title 9, Chapter 11, Section 1820.220(j)(5)(A)-(B). Administrative days must be authorized by a Physician Advisor. Discharge shall occur at the earliest opportunity following resolution of the problems preventing discharge. Under no circumstances shall administrative days be granted unless the patient was admitted on an acute level of care. A child who has been admitted to another facility on an acute status and is transferred to UCSD CAPS to await disposition shall be considered to have one continuous hospitalization and is eligible for administrative days if all other criteria are met, including the acute admission note from the transferring hospital. Documentation is required in the medical record that there is no appropriate non-acute treatment facility and the status of placement option(s), including date(s) and signature of the person making the contact in accordance with cited regulations (Attachment 3).

Determination of Funding:

Responsibility of payer of mental health services rendered is determined by financial eligibility and the Payment Authorization Request.

Financial Eligibility is determined prior to admission for care, if possible, or at the time of admission. A written eligibility inquiry is completed by the responsible UCSD CAPS staff. All patients are checked for Medi-Cal eligibility on admission, at the first of each month during the stay (if applicable), and at discharge. Children and adolescents are eligible for SD/MC benefits when all other criteria are met and they meet the age requirement.

Short Doyle/Medi-Cal must be used prior to realignment funds if the patient is eligible. Realignment funding is the funding of last resort and cannot be used until all other resources are exhausted. Funding may be shifted from one source of funding to another as financial eligibility or the condition of the patient changes, or when the patient or patient's representative does not identify the patient as eligible to receive benefits and the eligibility is later discovered.

Performance of Payment Authorization:

California Code of Regulations, Title 9, Chapter 11, Section 1820.215(a)(2)(A).

Inpatient Hospital Services

a. Payment Authorization Process – This plan applies to the UCSD CAPS program. The County of San Diego has contracted with Telecare, Inc. to perform payment authorization in accordance with the California Code of Regulations, Title 9, Chapter 11, Section

1820.215(a)(2)(A). All reviews must be conducted by a qualified and licensed reviewer and all determinations must be adequately supported by documented clinical evidence. Each case is reviewed by the Physician Advisor and approved or denied on the basis of individual need, care and determination of funding after discharge. Payment authorization is retrospective and determined after the patient is discharged.

b. Denials – All denials will be reviewed and determined by the Point of Authorization's Physician Advisor.
c. Oversight—The County of San Diego's Mental Health Plan is responsible for oversight of the payment authorization process.
d. Payment Authorization is a retrospective payment authorization process.

Level of Care Changes:

When the patient is determined to no longer meet medical necessity criteria, the level of care changes from medically necessary (acute) to non-medically necessary. Only a Physician Advisor may approve non-medically necessary days. The non-medically necessary level of care can return to the acute level of care if the need for acute care and medical necessity criteria can be justified and documented in the patient's record. All acute and non-medically necessary levels of care are determined retroactively upon review by the Physician Advisor.

The exacerbation of symptoms is not considered a new episode. The patient's acute care status is restored on the date the exacerbation is determined.

Payment Authorization Request (PAR):

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Section 456.211;
California Code of Regulations, Title 9, Chapter 11, Section 1820.220(c)(2)

UCSD CAPS informs the Utilization Review Specialist of each child's admission, funding source, and discharge. UCSD CAPS must inform the Point of Authorization of the child's discharge within 14 calendar days and submit a Payment Authorization Request (PAR) to the Payment Authorization Review Specialist for either acute or administrative stay. The PAR is initiated on admission and is then completed by the URC or designee. The Payment Authorization Specialist submits it to the Physician Advisor within 14 calendar days of receipt. A completed PAR signed by the Physician Advisor and documenting approved/denied days, is given to the CAPS Medical Record Technician to enter into the County's billing system. A copy is also forwarded to hospital administration for the Utilization Review Committee, as well as the County's Program Monitor.

The PAR contains identifying information (name, age, sex, birth date, medical record number); legal status on admission; date of admission; funding source; recipient's physician, diagnosis on admission; a brief summary of admission details; a mental status exam and plan of care. The URC or designee documents each day the child or adolescent is hospitalized for medical necessity on an attachment to the PAR. The Physician Advisor reviews the PAR and the clinical record to make a determination of appropriate payment. A separate PAR is submitted for each level of care change requested. The number of days requested, the number of days approved or denied, with supporting documentation and the Physician Advisor's signature, complete the PAR process.

Final Payment Authorization and Timeline:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.237-238;
California Code of Regulations, Title 9, Chapter 11, Section 1820.210

If the complete stay does not appear to be medically necessary, the case will be reviewed completely by the Physician Advisor after the child is discharged. Decisions for approval or denial of days shall be made not more than 14 (fourteen) calendar days after submission to the Physician Advisor. A copy of each Payment Authorization Request documenting approval or denial of days will be sent to the hospital's administrative office. A log/summary of patient days and denials is then prepared by hospital administration for review by the Utilization Review Committee including the attending physician and Medi-Cal agency.

Appeals:

California Code of Regulations, Title 9, Chapter 11, Section 1850.305

Should a disagreement occur between the UCSD CAPS attending physician and the County Contracted Physician Advisor, the case may be appealed. The appeal is to be submitted in writing within 90 days of the date of denial, and sent to the County. The County will appoint a County Physician for the purpose of evaluation of the appeal, which shall be completed within 60 days. If the appeal is denied, or if the county does not respond within 60 days, the appellant may submit a written request, within 30 days, to the California State Department of Mental Health. UCSD CAPS may access the provider appeal process any time before, during, or after the provider problem resolution process has begun when the complaint concerns a denied or modified request for payment authorization or payment of a provider's claim.

Discharge Planning:

The UCSD CAPS facility shall develop and maintain a written discharge planning procedure that provides for early initiation of such planning in order to facilitate discharge as soon as care at the present level is no longer necessary. Discharge planning should achieve placement at the lowest level of care reasonable in relation to health and safety. Reviews shall assess the current status of discharge plans, including availability of alternate placements. Discharge planning shall be documented at least weekly.

Medical Record Requirements:

The UCSD CAPS facility shall maintain compliance with the Federal Code of Regulations, the California Code of Regulations, and the contract between San Diego County Mental Health Plan and the Department of Mental Health. Each individual's medical record must include at least the following:

1. Identification data (i.e. name, age, date of birth, address, telephone number, Medi-Cal beneficiary number, date of admission, etc.
2. Evaluation/assessment, both psychiatrically and physically.
3. Five (5) axes DSM-IV-TR diagnoses.

4. Treatment Plan.
5. Name of medical staff member(s) responsible for individual's care.
6. Discharge summary.
7. All other pertinent health record information.
8. Each record entry shall be dated and signed using appropriate titles.
9. Record entries must be legible.
10. Medical doctors must be clearly identified.
11. Unlicensed professional staff and medical student entries must be co-signed resident physicians do not require a co-signature).

Confidentiality of Medical Records:

Code of Federal Regulations, Title 45, Subtitle A, Subchapter C, Parts 160 &164

UCSD CAPS must keep all records confidential and shall only disclose minutes and records in accordance with applicable state and federal laws. They shall be made available for County of San Diego, State Department of Mental Health and State Department of Health Services inspection upon request, as well as relevant federal agencies. In addition, copies of reports and records must be available to Committee members, county, state, and federal surveyors.

Audits:

As a contracted facility, UCSD CAPS is subject to the same audit process as a County operated facility would be. In addition, UCSD CAPS is subject to State and Federal Audits as a provider of Short Doyle/Medi-Cal services.

Attachment 1 – Admission Criteria

For Medi-Cal reimbursement for an admission to a psychiatric inpatient hospital, the beneficiary shall meet medical necessity criteria set forth in 1 and 2 below.

1. One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, Text Revision, published by the American Psychiatric Association:
    a. Pervasive Developmental Disorders
    b. Disruptive Behavior and Attention Deficit Disorders
    c. Feeding and Eating Disorders of Infancy or Early Childhood
    d. Tic Disorders
    e. Elimination Disorders
    f. Other Disorders of Infancy, Childhood, or Adolescence
    g. Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
    h. Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
    i. Schizophrenia and other Psychotic Disorders
    j. Mood Disorders
    k. Anxiety Disorders
    l. Somatoform Disorders
    m. Dissociative Disorders
    n. Eating Disorders
    o. Intermittent Explosive Disorder
    p. Pyromania
    q. Adjustment Disorders
    r. Personality Disorders

2. A beneficiary must have both a and b:

    a. Cannot be safely treated at a lower level of care; and

    b. Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either 1 or 2 below:

        1) Has symptoms or behaviors due to a mental disorder of one of the following:

            a) Represent a current danger to self or others, or significant property destruction
            b) Prevent the beneficiary from providing for, or utilizing food, clothing, or shelter
            c) Present a severe risk to the beneficiary's physical health
            d) Represent a recent, significant deterioration in ability to function

2) Require admission for one of the following:
    a) Further psychiatric evaluation
    b) Medication treatment
    c) Other treatment that can be reasonably provided only if the patient is hospitalized.

Attachment 2 - Continued Stay Criteria

Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:

1. Continued presence of indicators that meet the medical necessity criteria as specified in Attachment 1.
2. Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
3. Presence of new indicators that meet medical necessity criteria specified in Attachment 1.
4. Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.

An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

Attachment 3 – Short-Doyle Medi-Cal Administrative Days Policy

"Administrative Day Services" means psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at appropriate, non-acute treatment facilities.

Requests for MHP payment authorization for administrative day services shall be approved by an MHP when the following conditions are met in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the hospital and the MHP:

1) During the hospital stay, a beneficiary previously has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.

2) There is no appropriate, non-acute treatment facility in a reasonable geographic area and the medical record maintains documentation of contacts with a minimum of five appropriate, non-acute treatment facilities per week subject to the following requirements:

    a) Point of Authorization staff may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

    b) The lack of placement options at appropriate, non-acute residential treatment facilities and the contacts made at appropriate facilities shall be documented to include but not be limited to:

        I. The status of the placement option
        II. Date of the contact
        III. Signature of the person making the contact.

Attachment 4 – Interpretive Guidelines for Medical Necessity Criteria

SAN DIEGO COUNTY CHILDREN'S MENTAL HEALTH SERVICES
CHILD & ADOLESCENT MEDICAL NECESSITY CRITERIA
INTERPRETIVE GUIDELINES

MEDICAL NECESSITY CRITERIA	ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
Danger to self	Active and current suicidal threats or behavior may include extreme forms of self-mutilation or harm.	Remains suicidal with intent and plan; on suicide precautions; less restrictive level of care not possible. Intensive services needed, intrusiveness and pervasiveness of the suicidality intent and plan present, other risk factors in evidence.	Patient can contract for safety or symptoms can be managed at less restrictive level of care even though patient may continue to feel hopeless, helpless, or have suicidal ideation.
Danger to others/destruction of property.	Active violent or destructive behavior which presents imminent risk to others or property.	Active violent or destructive behavior with continued imminent risks to others or property present.	Behaviors no longer endangering others or destructive to property; threatening behaviors can be managed at a less restrictive level of care.
Unable to utilize food, shelter or clothing.	Inability to perform age appropriate self-care skills, unable to use food, shelter, or clothing in a way that meets basic needs.	Self care skills performed only with intensive assistance from facility staff.	Able to perform age appropriate self care with prompting; able to utilize food, shelter, and clothing to meet basic needs.
Presents a severe risk to the beneficiary's physical health.	Physical health severely jeopardized due to inability to care for self.	Physical health managed only with health care team's intensive interventions and direction.	Physical health can be managed at a less restrictive level of care.
Recent and dramatic deterioration in ability to function.	Demonstrable absence of, or severely compromised, ability to function.	Remains unable to function without intensive staff supervision or secure setting.	Able to function at less restrictive level of care.

County of San Diego
Health and Human Services Agency
Children's Mental Health Services

for

University of California San Diego
Child and Adolescent Psychiatry Service

UTILIZATION REVIEW PLAN

FISCAL YEAR 2005 - 2006